MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

NOTICE OF PROPOSED POLICY

Public Act 280 of 1939, as amended, and consultation guidelines for Medicaid policy provide an opportunity to review proposed changes in Medicaid policies and procedures.

Please review the policy summary and the attached materials that describe the specific changes being proposed. Let us know why you support the change or oppose the change.

Submit your comments to the analyst by the due date specified. Your comments must be received by the due date to be considered for the final policy bulletin.

Thank you for participating in the consultation process.

Director, Program Policy Division
Bureau of Policy and Federal Affairs
Medical Services Administration

Project Number:	0330-AP	**Comments Due:**	7/15/03	**Proposed Effective Date:**	10/1/03

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Policy Subject: Revised Chapter I, Coordination of Benefits, Chapter, and Directory Appendix

Affected Programs: Medicaid, Children's Special Health Care Services, State Medical Program, Maternal Outpatient Medical Services

Distribution: All Provider

Policy Summary: The revised chapters incorporate policies previously issued via bulletins, and updates contact information and current processes. It also introduces the new manual page layout and writing style.

Proposed Policy Draft

Michigan Department of Community Health
Medical Services Administration

Distribution: All Providers

Issued: xxxxxxx, 2003

Subject: Changes to Chapter I and Coordination of Benefits Chapter

Effective: October 1, 2003 (proposed)

Programs Affected: Medicaid, Children's Special Health Care Services, MOMS, State Medical Program

This bulletin transmits proposed revisions to Chapter I (General Information for Providers) and the Coordination of Benefits Chapter (previously Appendix C) of your Provider Manual, along with a newly developed Directory Appendix. The revised chapters include policy changes that have been previously transmitted to you via policy bulletins, as well as updates to reflect current processes, organizational structures, and contact information.

As you will note, the format of the chapters is new. The Department of Community Health is in the process of updating all provider manuals with the goal of creating a single, all-inclusive manual that will be updated annually, distributed via compact disc, and also be available through the internet. (The Department will continue the current process of issuing paper policy bulletins throughout the year as needed.) The new manual will allow the user to locate information through word searches and have internal links between related sections. As each chapter of the current provider manual library is updated, it will be rewritten in a common writing style and format. (Your comments/suggestions on the new look and readability of the chapters are welcome.)

During the updating of the manuals/chapters, some information is being relocated to different areas. In general, information that is applicable only to a particular type of provider (e.g. hospitals, health plans) has been removed from the general information chapter and is being placed in the provider-specific chapters. (As you review and comment on the attached chapters, please make note of any topics that you think may be missing. We will verify that the information has been relocated to another part of the manual that will be distributed for your review at a later date.)

The Directory Appendix, along with a Forms Appendix, is still in development. As each of the manuals/chapters undergo revision, contact information is being moved to the Directory Appendix to create a ready reference for providers and for ease of updating. The Forms Appendix will group all forms and completion instructions in a single location. (Your ideas/comments regarding what information is provided in the Directory Appendix and how it is organized are encouraged.) The intent is to make this a user-friendly resource.

Chapter I – General Information for Providers

Table of Contents

Section 1 - Introduction

The Michigan Department of Community Health (MDCH) acts as the fiscal intermediary for several health insurance programs including the Medicaid Program; State Medical Program (SMP); Children's Special Health Care Services (CSHCS), the Refugee Assistance Program (RAP), Maternity Outpatient Medical Services (MOMS) and the Repatriate Program. Although coverage, limitations, and administration may differ, billing procedures and reimbursement methods are essentially the same.

This chapter is used for all health insurance programs administered by MDCH. Any reference to the Medicaid Program in the manual and bulletins pertains to all programs administered by MDCH unless specifically stated otherwise. Reference to the state mental health facilities includes only those facilities owned and operated by MDCH. It does not include proprietary facilities for the mentally ill or developmentally disabled.

1.1 Bulletins

Since this manual is the provider's primary source of information, it is very important the manual be kept up-to-date. Revisions to the manual containing policy and procedural changes are sent to the provider via Policy Bulletins. Bulletins should be kept until the information is incorporated into the manual. Bulletins are numbered for the provider's reference. A four-digit number appears at the top of the bulletin following "Distribution." The first two digits of the bulletin number refer to the year. The next two digits refer to the specific sequence number assigned to the bulletin (e.g., 03-04).

Bulletins are sent to affected providers and are posted on the MDCH website.

1.2 Numbered Letters

The purpose of a numbered letter is to educate, inform, and/or clarify issues related to MDCH policies, procedures, and/or decisions that affect multiple providers.

1.3 Inquiries

MDCH has several methods of resolving inquiries. Questions regarding policies and procedures should be directed to Provider Inquiry. (Refer to the Directory Appendix for contact information.)

1.3.A. Provider Information Line

If billing assistance is required, the Provider Inquiry Line is available for immediate resolution of inquiries. (Refer to the Directory Appendix for contact information and hours of operation.)

1.3.B. Written Inquiries

Complex problems may require research and analysis. The problem should be clearly explained in writing, with complete documentation (e.g. RA) attached and sent to Provider Inquiry.

1.4 Beneficiary Medical Assistance Line

If assistance to the beneficiary is required, the Beneficiary Help Line is available to assist them. (Refer to the Directory Appendix for contact information and hours of operation.)

Within the limits of the Medicaid Program, MDCH does not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, handicap, political beliefs, or source of payment.

1.5 Reporting Fraud and Abuse

Any provider, beneficiary, or employee who suspects Medicaid fraud or abuse is encouraged to report that information to the MDCH. Information about fraud and abuse reporting requirements is located in the department's website. See the Directory Appendix for website and contact information.

Section 2 - Provider Enrollment

2.1 Medicaid Program Overview

The Medical Services Administration within the MDCH administers the Michigan Medicaid Program. The following conditions of participation are requirements for all enrolled providers unless stated otherwise.

2.2 General Information

An eligible provider who complies with all licensing and regulation laws applicable to the provider's practice or business in Michigan, and whose services are directly reimbursable per MDCH policy, may enroll as a provider in the Medicaid Program. Borderland providers and, under certain circumstances, beyond borderland providers must be licensed and/or certified by the appropriate standard-setting authority in their home state. (Refer to the "Beyond Borderland Area" section of this chapter for more information.) In addition, some providers must also be certified as meeting Medicare or other standards as specified by the MDCH.

Providers must have a completed and signed Medical Assistance Provider Enrollment Agreement (DCH-1625) on file with the Provider Enrollment Unit to be reimbursed for covered services rendered to Medicaid beneficiaries.

A provider's participation in the Medicaid Program is effective on the date the provider signs the Medical Assistance Provider Enrollment Agreement (DCH-1625) if the Provider Enrollment Unit, Bureau of Finance, receives the application within thirty calendar days of the signature date. If the application/agreement is not received within thirty calendar days of the signature date, the provider's enrollment is effective on the date it is received and date-stamped by the Provider Enrollment Unit.

The provider may request, in writing, that enrollment be retroactive. The request should be addressed to the Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

Retroactive enrollment is not considered prior to the effective date of licensure/certification or provider reinstatement. Enrollment may be retroactive one year from the date the request is received if the provider's licensure/certification or reinstatement is effective for that entire period. Retroactive enrollment eligibility is not a waiver for claims/services that do not meet established Medicaid billing criteria.

Once enrolled, providers are sent the DCH Provider Turnaround document. This is a computer printout of data on file with the Provider Enrollment Unit. This document is not to be returned to the MDCH.

The Provider Enrollment Unit does not issue a group provider identification (ID) number for group practices. Each provider (e.g. physician, dentist, etc.) within a group must enroll as a Medicaid provider. Each service rendered by a provider in a group must be billed using that provider's individual ID number. If a provider renders services at several service office locations/sites, the provider must have a separate ID number identifying each individual service location/site. A service office location/site is defined as a physical facility where a provider conducts business operations. The facility and its operations would include:

- Seeing patients;
- Maintaining staff;
- Having established hours; and

- Storage of medical records.

If a provider does not normally practice in an office (e.g., anesthesiologist), then separate ID numbers are not required.

For information regarding substitute physician or a locum tenens arrangements, refer to the Practitioner Chapter of this manual.

A Medicaid Health Plan (MHP) is responsible for reimbursing a subcontractor for its services according to the conditions stated in the subcontract. The MHP must also reimburse referrals to any providers that do not have a subcontract.

Section 3 - Maintenance of Provider Information

Providers must notify MDCH immediately, in writing, of changes affecting their enrollment information. Changes must be sent to the Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

Examples of such changes include:

- A change in the provider's Federal Employer ID Number (or Tax ID Number);
- Moving to a new office;
- Adding another office or location;
- Leaving the current employer/partnership;
- Changing the billing address to which warrants and RAs only are sent;
- Retiring from practice;
- Closing a business;
- Provider files Chapter 11, Reorganization;
- Provider files Chapter 7, Bankruptcy;
- Any action taken by a licensing authority or hospital that affects health care privileges;
- Any criminal conviction;
- Addition/change of a specialty (a copy of the Letter of Congratulations or, upon certification, a certificate is required);
- Employer/partnership additions or changes;
- Change/loss of licensure status;
- New employees/providers;
- New contractual obligations to a clinic, employer, contractor, or other entity;
- Clinical Laboratory Improvement Act (CLIA) changes; and/or
- A change in ownership.

Nursing Facility (NF) providers should refer to the Nursing Facilities Coverage & Limitations Chapter of their manual for additional instructions.

Some of these changes may result in termination or a change in the provider ID number. Failure to notify MDCH of any change in identification information may result in the loss of Medicaid enrollment, lapse of provider eligibility, or nonpayment of services.

The Provider Enrollment Unit disenrolls providers if mail is returned as non-deliverable.

Section 4 – Compliance with Federal Legislation

4.1 Disclosure

The provider shall notify the Michigan Department of Consumer and Industry Services (DCIS) and MDCH Provider Enrollment of any person(s) with an ownership or controlling interest in a facility that has been convicted of a criminal offense related to their involvement in any programs under Medicare, Medicaid, or Social Services Block Grants since the inception of these programs.

4.2 Nondiscrimination

Federal regulations require that all programs receiving federal assistance through Health and Human Services (HHS) comply fully with Title VI of the Civil Rights Act of 1964 and Section 504 of the Rehabilitation Act of 1973. Providers are prohibited from denying services or otherwise discriminating against any medical assistance recipient on the grounds of race, color, national origin or handicap. For complaints of noncompliance, contact the Michigan Department of Civil Rights or the Office of Civil Rights within the U.S. Department of Justice. (Refer to the Directory Appendix for contact information.)

Section 5 – Termination of Enrollment

5.1 General Information

The name of any provider or provider organization suspected of fraudulent practices, misuse or abuse of protected health information in relation to Health Insurance Portability and Accountability Act of 1996 (HIPAA) privacy requirements or suspected of accepting or soliciting unearned rebates, refunds, receipt of free goods, or other unearned considerations, in the form of money or otherwise, is referred to the Office of Civil Rights, the Department of Attorney General or to the Office of the United States Attorney for investigation and possible prosecution under applicable state and/or federal statutes. In the event of a disqualifying action (e.g., loss of license or certification, suspension or exclusion), providers are immediately terminated from participation in the Medicaid Program on the effective date of the disqualifying action.

The following is considered grounds for termination or refusal to renew the provider's participation in the Medicaid Program:

- Any actions that threaten the health, safety, or welfare or privacy of protected health information of Medicaid beneficiaries;
- Any actions that threaten the fiscal integrity of the Medicaid Program;
- Violation of contractual obligations;
- Continued failure to correct cited inappropriate services or billing actions;
- Failure to comply with the conditions of participation;
- Abuse of patient trust funds (Nursing Facilities only);
- Failure to meet certification standards;
- A pattern of providing inappropriate or unnecessary services to a beneficiary; and
- Termination or exclusion from the Medicare Program.
- Conviction under Medicaid or Health Care False Claim Act or similar state/federal statute.

Summary suspension prevents further payment after a specified date.

If an indication of fraud or Medicaid misuse/abuse is discovered during any of the following, MDCH considers it as a basis for summary suspension:

- An evaluation of billing practices;
- The prior authorization process;
- An on-site review of financial and medical records and a written report of this review is filed;
- The construction of a profile to evaluate patterns of utilization of Medicaid beneficiaries served by the provider;
- A peer review of services or practices;
- A hearing or conference between MDCH and the provider (and counsel, if so requested) Or
- Indictment or bindover on charges under the Medicaid or Health Care False Claim Act or similar state/federal statute.

5.2 Loss of Licensure

For providers who must be licensed to practice their profession, continued enrollment in Medicaid is dependent upon maintaining licensure. Failure to renew a provider's license results in disenrollment from the Medicaid Program effective the date of final expiration of the provider's license.

Suspension or revocation of a provider's license by the appropriate standard setting authority results in termination of Medicaid participation effective on the date the provider is no longer licensed. In the case of a provider not located in Michigan, suspension or revocation would be administered by the appropriate state licensing board.

If a provider is no longer licensed to practice (e.g., the license was suspended, lapsed, or revoked), MDCH does not reimburse for services rendered or ordered by that provider after the termination of the license. Medicaid payments obtained for services rendered during a period when the provider was unlicensed must be refunded to the State.

Once a provider's license is reinstated, the Provider Enrollment Unit may be notified, in writing, to request re-enrollment as a Medicaid provider.

Section 6 – Sanctioned and Nonenrolled Providers

6.1 Sanctioned Providers

The Medicaid Program does not reimburse providers for any services rendered that were ordered/prescribed by sanctioned (suspended, terminated or excluded) providers. If a provider is presented with an order/prescription from a sanctioned provider, that provider should inform the beneficiary that the order/prescription could not be filled because the ordering/prescribing provider has been suspended from the Medicaid Program. The beneficiary may purchase the service if he understands why the service is not covered by Medicaid and agrees to pay for the service**.**

Notice of a provider's sanction is issued in Medicaid Bulletins. In order to ensure providers receive timely notification regarding sanctioned providers, a notifying bulletin, including a cumulative list of sanctioned providers, is printed twice a year. Other qualifying bulletins showing additions and deletions to the sanctioned provider list are issued on a monthly basis. A copy of the cumulative list is also available on the MDCH website at the address noted in the Directory Appendix.

Providers should check each name and Medicaid ID number on the list closely to avoid accepting orders/prescriptions for Medicaid beneficiaries from these sanctioned providers. The list is also distributed to providers and to Family Independence Agency (FIA) county offices each time a provider is sanctioned as a result of Medicaid initiating the sanction.

The Bulletin also includes providers who have been sanctioned by other programs (e.g., Medicare). If the source has suspended, terminated, or excluded a provider from participation, that action remains applicable to Medicaid even if that provider has not been included on Medicaid's list of sanctioned providers. Any payments that may be unintentionally made to a provider acting on an order/prescription from a sanctioned provider, for dates of service on or after the dates indicated on the list, must be refunded to the Medicaid Program.

6.2 Nonenrolled Michigan and Borderland Providers

Medicaid pays nonenrolled Michigan and nonenrolled borderland providers for emergency services and for the first claim for non-emergency services. When a nonenrolled Michigan and Borderland provider submits a claim for non-emergency services, the Miscellaneous Transaction Unit (MTU) processes the claim and sends a letter to the provider with an enrollment application inviting him to enroll in the Program. If the provider elects not to enroll in the Medicaid Program and submits another claim(s) for non-emergency services for payment, the Miscellaneous Transaction Unit returns the claim(s) with another application for enrollment. This second invitation to enroll states that if the provider chooses not to enroll, the claim(s) will not be paid. The provider and the beneficiary must then make their own payment arrangements for the service(s).

6.3 Beyond Borderland Area

Reimbursement for services rendered to eligible beneficiaries is normally limited to those providers enrolled in the Medicaid Program. MDCH reimburses nonenrolled providers who are beyond the borderland area if:

- The service is necessary because of a medical emergency (as defined by Medicaid);
- Medicare has paid a portion of the service and the provider is billing for the coinsurance and/or deductible amounts;

- The service is necessary because the beneficiary's health would be endangered if he were required to travel to Michigan; and
- The service is prior authorized by MDCH.

Providers must be licensed and/or certified by the appropriate standard-setting authority.

Providers must submit the claim to the MTU. Nonenrolled providers do have a responsibility to follow Michigan Medicaid policies, including obtaining prior authorization for those services that require prior authorization by enrolled Michigan providers.

All non-emergency services rendered by providers require the referring physician to obtain written prior authorization from the MDCH as indicated in the "Prior Authorization" section of this chapter.

When a Michigan provider has referred a Medicaid beneficiary to a provider beyond the borderland area, the referring provider should instruct the provider to contact the Miscellaneous Transactions Unit. (Refer to the Directory Appendix for contact information.)

Borderland is defined as a county that is contiguous to the Michigan border. It also includes the five major cities beyond the contiguous county lines. The borderland area includes:

Indiana	Fort Wayne (city); Elkhart, LaGrange, LaPorte, St. Joseph, and Steuben (counties)
Ohio	Fulton, Lucas, and Williams (counties)
Wisconsin	Ashland, Green Bay, and Rhinelander (cities); Florence, Iron, Marinette, Forest, and Vilas (counties)
Minnesota	Duluth (city)

Section 7 - Delivery of Services

7.1 Free Choice

Beneficiaries are assured free choice in selecting an enrolled licensed/certified provider to render services, unless they are patients in a state-owned and -operated psychiatric facility or enrolled in a Medicaid Health Plan or PLUS CARE.

7.2 Rendering Services

Enrollment in the Medicaid Program does not legally require a provider to render services to every Medicaid beneficiary seeking care, except as noted below. Providers may accept Medicaid beneficiaries on a selective basis. However, a Medicare participating provider must accept assignment for Medicare and Medicaid dual eligibles.

Hospitals must provide emergency services as required by the Emergency Medical Treatment and Active Labor Act (EMTALA), 42USC 1395dd.

Hospitals must also provide for elective admissions and services (not required to be provided by EMTALA) that have been arranged by a physician who has admitting privileges at the hospital, where beds, services and adequate resources are available.

If a Medicaid-only beneficiary is told and understands that a provider is not accepting them as a Medicaid patient and asks to be private pay, the provider may charge the patient for services rendered. The beneficiary must be advised prior to services being rendered that their Medicaid card is not accepted and that they are responsible for payment.

All such services rendered must be in compliance with the provider enrollment agreement; contracts (when appropriate); Medicaid policies; and applicable county, state, and federal laws and regulations governing the delivery of health care services. (Refer to the "Billing the Beneficiary" section of this chapter for more information.)

7.3 Noncovered Services

When the beneficiary needs a medical service recognized under State Law, but not covered by Medicaid, the service provider and the beneficiary must make their own payment arrangements for that noncovered service. A beneficiary must be informed, prior to rendering of service, that Medicaid does not cover the service. For Nursing Facilities, a Medicaid beneficiary can use his patient-pay funds to purchase noncovered services subject to MDCH verification of medical necessity and the provider's usual and customary charge. (Refer to the provider-specific “Coverages and Limitations” chapter for more information.)

7.4 Nondiscrimination

Providers must render covered services to an eligible beneficiary in the same scope, quality, and manner as provided to the general public. Within the limits of the Medicaid Program, providers shall not discriminate on the basis of age, race, religion, color, sex, handicap, national origin, marital status, political beliefs, or source of payment.

7.5 Service Acceptability

MDCH may determine that a provider did not render services within the scope of currently accepted medical/dental practice or the service was not provided within the limitations of the Program. In such cases, MDCH reviews the situation and may:

- Refuse to reimburse for the service;
- Require the provider to repeat or correct the service at no additional charge to Medicaid or the beneficiary (e.g., an inaccurate vision prescription was written);
- Recover any monies paid to the provider for the service; and/or
- Require the service to be done immediately (e.g., provide services to complete an incomplete examination or treatment).

Failure to comply with any of the last three items may result in the provider's disenrollment from the Medicaid Program.

Section 8 - Prior Authorization

8.1 General Information

There may be occasions when a beneficiary requires services beyond those ordinarily covered by Medicaid or needs a service that requires prior authorization. In order for Medicaid to reimburse the provider in this situation, MDCH requires that the provider obtain authorization for these services before the service is rendered. Providers should refer to their provider-specific "Coverages and Limitations" chapter for prior authorization requirements. (Refer to the Directory Appendix for contact information for prior authorization.)

Prior authorization may not be required if the beneficiary has Medicare or other insurance coverage. (Refer to the Coordination of Benefits chapter for details.)

8.2 Processing of Requests

Based on documentation submitted, the prior authorization request is approved, disapproved, or returned for more information. Results of the request are returned to the provider via a letter or a copy of the prior authorization form, whichever is applicable. Providers must immediately notify the beneficiary of the approval or denial of the prior authorization request.

Approval of a prior authorization request does not verify beneficiary eligibility. It is the provider's responsibility to verify the beneficiary's eligibility for the date a service is actually rendered.

8.2.A Verbal Prior Authorization

If a service requires prior authorization but the situation requires immediate action to diagnose or correct a medical condition or avoid further damage, the provider may request prior authorization by calling the MDCH Prior Authorization Section. Refer to the Directory Appendix for contact information.

If the service is required at a time when MDCH cannot be contacted, the provider may perform the service and call MDCH by the end of the next working day.

After verbal authorization is obtained, the provider must submit a written prior authorization request (with supporting documentation) to the MDCH. If the supporting documentation matches the information relayed for verbal authorization, MDCH sends an approval to the provider.

8.2.B Approval

Payment is made only for services provided during the period of time the prior authorization is valid and the beneficiary is eligible for Medicaid. Providers should carefully review the approval as it is for specific services and may be for only a specific period of time.

The service prior authorized must be the service that is rendered and billed. If there are changes in the plan of treatment or if the approved service does not accurately reflect the service to be provided, the Prior Authorization Section should be contacted prior to rendering the service.

If a beneficiary elects to accept a service other than the service that was authorized and that service also requires prior authorization, which was not obtained or is not covered by Medicaid,

the beneficiary is responsible for payment of the entire service. In this situation, the provider must notify the beneficiary prior to rendering the service that the service is not covered by Medicaid and the beneficiary is financially responsible for the entire service. It is suggested the beneficiary acknowledge this responsibility in writing.

8.2.C Denial

If prior authorization for the service is denied, it must not be billed to Medicaid. Once notified of the denial, the beneficiary may still wish to receive the service. The provider must inform the beneficiary prior to rendering the service that the service is not covered by Medicaid and the beneficiary is financially responsible for the entire service. It is suggested the beneficiary acknowledge this responsibility in writing.

8.2.D Reimbursement

For most providers, procedure codes that do not have an MDCH established fee screen, or need special pricing, require documentation to be sent with the claim. For some types of services, the special pricing review is completed through the PA process. In these cases, the Program will include the allowable fee rate on the approved PA.

Medicaid does not provide reimbursement if:

- The beneficiary was not eligible for Medicaid on the date of service. Reimbursement is denied on this basis even if the service has been prior authorized. **Exception:** For customized equipment and devices, the beneficiary must be eligible for Medicaid on the date the item/service was ordered to be eligible for reimbursement.
- A service that is prior authorized is rendered in conjunction with a service that is not a separately reimbursable service and is not a Medicaid benefit.
- A service that is prior authorized and rendered in conjunction with another service that requires prior authorization and prior authorization for the second service was not obtained.
- Prior authorization was required but was not obtained.
- Beneficiary has other insurance and the rules for coverage for other insurance were not followed.
- It was determined that prior authorization was obtained after the service was rendered. (The provider should refer to "Verbal Prior Authorization" above for an exception to this situation.)
- The service/product was ordered or prescribed by a provider who has been sanctioned from the Medicaid Program, and the sanction was effective before prior authorization was granted.

Providers cannot charge the beneficiary or beneficiary's representative for the provider's failure to obtain prior authorization. If the provider failed to obtain prior authorization for a service and the service was rendered, he cannot apply his fee for that service in calculating other reimbursement due to him from Medicaid.

8.3 Prior Authorization (Medicaid Health Plans (MHPs) Only)

MHPs are responsible for authorizing all Medicaid-covered services in the Comprehensive Health Care Program (CHCP) benefit package for enrolled Medicaid beneficiaries, with certain exceptions such as emergency services. Providers must contact the MHPs before rendering services to MHP enrollees to obtain prior authorization. Each MHP is responsible for establishing procedures for prior authorization.

8.4 Custom-Made Medical Equipment, Devices and Medical Supplies

The Medicaid Program is responsible for payment of custom equipment or devices, hearing aids, eye glasses, dentures, prosthetics and orthotics authorized and ordered before the last date of Medicaid eligibility and delivered within 30 days after loss of eligibility. This policy also applies to enrollment changes that signify a change in payment responsibility similar to the loss of eligibility.

The Program or MHP that authorizes and orders the equipment or item is responsible for paying for the item even though it is delivered after the beneficiary loses eligibility or has an enrollment change (fee-for-service (FFS) to MHP, MHP to FFS or MHP to MHP). The order must be placed before the change in enrollment status and the service should be delivered within 30 days after the change in enrollment status.

If a provider determines that a beneficiary needs a durable medical equipment item that is authorized by either MDCH or the current MHP and is ordered before a change in enrollment status, the party that authorized the service is responsible for payment.

If a custom-made item, medical device, or equipment (e.g., prosthetic limb, custom-made medical equipment such as a brace, custom motorized wheelchair, orthotics) is ordered for a beneficiary during a hospital stay but is not delivered until after discharge and enrollment status changes, payment must be made by the party responsible for the hospital stay.

This policy does not apply to mass-produced, readily available items that can be used by a person other than for whom it was ordered. It also excludes all rental items, all expendable/disposable medical supply items (e.g., diapers, dressings, ostomy supplies, IV infusion supplies) or any item that does not require a length of time (days or weeks) to special order for a specific person.

Section 9 - Billing the Beneficiary

Providers cannot bill beneficiaries for services except in the following situations:

- A co-payment for chiropractic, dental, hearing aid, pharmacy, podiatric, or vision services is required.

- A monthly patient-pay amount for inpatient hospital or nursing facility services. The local FIA determines the patient-pay amount. Noncovered services can be purchased by offsetting the nursing facility beneficiary's patient-pay amount. (Refer to the provider-specific "Coverages and Limitations" chapter for more information.)

- For nursing facility (NF), state-owned and -operated facilities or Community Mental Health Services Program (CMHSP)-operated facilities determine a financial liability or ability-to-pay amount separate from the Family Independence Agency (FIA) patient-pay amount. The state-owned and -operated facilities or CMHSP-operated facilities liability may be an individual, spouse, or parental responsibility. This responsibility is determined upon initiation of services and is reviewed periodically. The beneficiary or his authorized representative is responsible for the state-owned and -operated facilities or CMHSP ability-to-pay amount, even if the patient-pay amount is greater.

- The provider has been notified by FIA that the beneficiary has an obligation to pay for part of, or all of, a service because services were applied to the beneficiary's spenddown amount.

- If the beneficiary is enrolled in a MHP or CSHCS Special Health Plan (SHP) and the health plan provider did not authorize a service, and the beneficiary had prior knowledge that he was liable for the service. It is the provider's responsibility to determine eligibility/enrollment status of each beneficiary at the time of treatment and to obtain the appropriate authorization for payment**.** Failure of the provider to do obtain authorization does not create a payment liability for the beneficiary.

- Medicaid does not cover the service. If the beneficiary requests a service not covered by Medicaid, the provider may charge the beneficiary for the service if the beneficiary has been told prior to rendering the service that it was not covered by Medicaid. If the beneficiary is not informed of Medicaid noncoverage until after the services have been rendered, the provider cannot bill the beneficiary.

- The beneficiary refuses Medicare Part A or B. The beneficiary may be billed.

- The amount the other insurance paid was paid to the policyholder. The policyholder may be billed.

- The beneficiary is the policyholder of the other insurance and the beneficiary did not follow the rules of the other insurance (e.g., utilizing network providers).

- The provider chooses not to accept the beneficiary as a Medicaid beneficiary and the beneficiary had prior knowledge of the situation. The beneficiary is responsible for payment.

Some services are rendered over a period of time (e.g., maternity care). Since Medicaid does not normally cover services when a beneficiary is not eligible for Medicaid, the provider is encouraged to

advise the beneficiary prior to the onset of services that the beneficiary is responsible for any services rendered during any periods of ineligibility. Exceptions to this policy are services/equipment (e.g., root canal therapy, dentures, customized seating systems) that began, but were not completed, during a period of eligibility. (Refer to the provider-specific "Coverages and Limitations" chapter for more information regarding exceptions.)

When a provider accepts a patient as a Medicaid beneficiary, the beneficiary cannot be billed for:

- Medicaid-covered services. Providers must inform the beneficiary before the service is provided if Medicaid does not cover the service.
- Medicaid-covered services for which the provider has been denied payment because of improper billing, failure to obtain prior authorization, or the claim is over one year old and has never been billed to Medicaid, etc.
- The difference between the provider's charge and the Medicaid payment for a service or for missed appointments.
- Copying of medical records for the purpose of supplying them to another health care provider.

If a provider is not enrolled in the Medicaid Program, they do not have to follow Medicaid guidelines about reimbursement, even if the beneficiary has Medicare as primary.

If a Medicaid-only beneficiary understands that a provider is not accepting him as a Medicaid patient and asks to be private pay, the provider may charge the beneficiary its usual and customary charges for services rendered. The beneficiary must be advised prior to services being rendered that his Medicaid card is not accepted and that he is responsible for payment. It is recommended that the provider obtain the beneficiary's acknowledgement of payment responsibility in writing for the specific services to be provided.

Section 10 - Billing Requirements

All claims must be submitted in accordance with the policies, rules, and procedures as stated in the manual.

10.1 Billing Provider

Providers must not bill MDCH for services that have not been completed at the time of the billing.

The provider who renders the service must bill for the service on the appropriate claim form using his own provider identification number for the location where the service was actually rendered.

Providers rendering services to the residents of the ICF/MR facility (Mt. Pleasant Regional Center) may not bill Medicaid directly. All covered services (e.g., laboratory, x-rays, medical surgical supplies including incontinent supplies, hospital emergency rooms, clinics, optometrists, dentists, physicians, and pharmacy) are included in the per diem rate.

10.2 Charges

Providers cannot charge Medicaid a higher rate for a service rendered to a beneficiary than the lowest charge that would be made to others for the same or similar service. This includes advertised discounts, special promotions, or other programs to initiate reduced prices made available to the general public or a similar portion of the population. In cases where a beneficiary has private insurance and the provider is participating with the other insurance, refer to the Coordination of Benefits chapter for further information.

10.3 Billing Limitation

Each claim received by MDCH receives a unique identifier called a Claim Reference Number (CRN). This is a ten-digit number found in the Remittance Advice (RA) which indicates the date the claim was entered into the MDCH Claims Processing System. The CRN is used when determining "active review" of a claim. (Refer to the “Billing and Reimbursement” chapter for more information.)

A claim must be initially received and acknowledged (i.e., assigned a CRN) by MDCH within twelve months from the date of service. The "date of service" has several meanings:

- For inpatient hospitals, nursing facilities, and MHPs, it is the "Through" or "To" date indicated on the claim.
- For all other providers, it is the date the service was actually rendered or delivered.

Claims over one year old must have continuous "active review" to be considered for Medicaid reimbursement. Claim replacement can be resubmitted within 12 months of the latest RA date or other activity.

“Active review” means the claim was received and acknowledged by MDCH within twelve months from the date of service. In addition, claims with dates of service over one year old must be billed within 120 days from the date of the last rejection. For most claims, MDCH reviews the claims history file for verification of active review.

Only the following types of claims require documentation of previous activity in the remarks section of the claim:

- Claim replacements;

- Claims previously billed under a different provider ID number;
- Claims previously billed under a different beneficiary ID number; and
- Claims previously billed using a different date of service, "statement covers period" for nursing facilities and inpatient hospitals.

If a claim is received after the initial twelve-month billing limitation, the resubmitted claim must include documentation of active review (i.e., CRNs and RA Pay Cycle dates/Pay Cycle Numbers). Documentation of active review for each consecutive 120-day period beyond the initial twelve months must be indicated.

There are occasions when providers are not able to bill within the established time frames (e.g., awaiting notification of retroactive beneficiary eligibility). In these situations, the provider should submit a claim to Medicaid, knowing the claim will be rejected. This gives the provider a CRN to document continuous active review.

Exceptions may be made to the billing limitation policy in the following circumstances.

- Department administrative error occurred, including:
  - The provider received erroneous written instructions from MDCH staff;
  - MDCH staff failed to enter (or entered erroneous) authorization, level of care, or restriction on the system;
  - MDCH contractor issued an erroneous prior authorization; and
  - Other administrative errors by the MDCH or its contractors that can be documented.

  Retroactive provider enrollment is not considered an exception to the billing limitation.

- Medicaid beneficiary eligibility/authorization was established retroactively:
  - Beneficiary eligibility/authorization was established more than twelve months after the date of service; and
  - The provider submitted the initial invoice within twelve months of the establishment of beneficiary eligibility/ authorization.

- Judicial Action/Mandate: A court or departmental administrative law judge ordered payment of the claim.

- Medicare Processing Was Delayed: The claim was submitted to Medicare within 120 days of the date of service and the claim was submitted to Medicaid within 120 days of the subsequent resolution by Medicare. Refer to the Coordination of Benefits Chapter for further information.

Providers who have claims meeting either of the first two exception criteria must contact their local FIA office to initiate the exception process. The FIA case worker must complete and submit the Request for Exception to the Twelve-Month Billing Limitation for Medical Services form (MSA-1038). The provider should contact the caseworker if the claim does not appear on a RA within 60 days.

10.4 Professional Corporation

For services involving multiple visits billed with a single procedure code (e.g., surgery and pre- and post-operative care, prenatal care) or "initial" or "new" services, the code/service may be billed only once by a professional corporation. Other members of the corporation may not bill separately any procedures related to the service. This policy includes services rendered in a partnership, employer-employee, or contractor relationships.

10.5 Invoice Completion Fee

A fee for completing the Medicaid claim cannot be charged to Medicaid, the beneficiary, or the beneficiary's representative.

10.6 Claim Documentation

In some cases, MDCH may require specific information with the claim (e.g., indication of medical necessity). Providers should refer to the "Coverages and Limitations" and "Billing and Reimbursement" chapters of the manual for the information that may be needed on the claim.

A claim without the requested information may be reviewed:

- Prior to payment. (The claim may be rejected for missing, incorrect or insufficient information.)
- Subsequent to payment. (A post-payment audit/review may indicate that the information was insufficient or missing and a gross adjustment would be initiated to recover the payment.)

10.7 Claim Certification

Providers certify by signature that a claim is true, accurate, and contains no false or erroneous information. The provider's signature or that of the provider's authorized representative may be handwritten, typewritten, or rubber-stamped on a paper claim.

When a provider's warrant is endorsed or deposited, it is certification that the services billed were actually provided. It further certifies that the claims (paper or electronic) paid by the warrant accurately document that the health care services provided were within the limitation of the Medicaid Program (or compliance with a contract). The warrant's certification applies to original claims as well as resubmitted claims and claim adjustments.

> *This does not apply to state-owned and -operated facilities as they do not receive a warrant.*

Providers are held responsible for any errors, omissions, or resulting liabilities that may arise from any claim for medical services submitted to MDCH under the provider's name or identification number. Contractual arrangements (verbal or written) with employers, employees, contractors, etc., do not release the provider of the responsibility for services billed or signed under the provider's ID Number.

Providers are responsible for the supervision of a subordinate, officer, employee, or contracted billing agent who prepares or submits the provider's claims.

10.8 Billing Agents

A billing agent who submits Medicaid claims via electronic media must be authorized by MDCH before submitting claims. The provider must then authorize the billing agent to submit his claims. The authorization must be submitted even if the provider is acting as his own billing agent. The provider must submit a completed Billing Agent Authorization (DCH-1343) to the MDCH Provider Enrollment Unit. (Refer to the Directory Appendix for contact information.)

After processing the DCH-1343, the Provider Enrollment Unit mails a letter, along with the DCH Provider Turnaround form, to the provider. The provider must then notify the billing agent that he may begin submitting claims on the provider's behalf.

MDCH notifies providers of changes to the Program by means of bulletins and letters. If the provider has a contract with a billing service, it is the provider's responsibility to notify the billing service of any changes that may affect claims submitted on his behalf. Providers are responsible for the claims submitted by the billing agent, including improper billings, duplicate payments, etc.

In the case of a billing agent who submits electronic claims, DCH-1343 represents the provider's signature. For the billing agent who submits paper claims, the billing agent's name should appear in the certification area of the claim. If the provider wishes to have his name appear in the certification area as well, it should precede the billing agent's name.

Section 11 - Third Party Liability

Federal regulations require that all identifiable financial resources available for payment, including Medicare, be billed prior to billing Medicaid. (Refer to the Other Insurance section of the Billing and Reimbursement chapter for more information.)

Medicaid will not reimburse for services provided to individuals being held in a detention facility against their will except for those directly related to an inpatient hospital stay (medical/surgical/psychiatric) provided in a non-state owned facility. All other services must be billed to the detention facility. The Eligibility Verification System will show Level of Care 88 with a provider ID of 3470136 for these individuals.

Section 12 - Reimbursement

12.1 Payment In Full

Providers must accept Medicaid's payment (or contracted capitation rate) as payment in full for services rendered, except when authorized by Medicaid (e.g., co-payments, patient-pay amounts, other cost sharing arrangements authorized by the State). The provider must not seek nor accept additional or supplemental payment from the beneficiary, the family, or representative in addition to the amount paid by Medicaid, even when a beneficiary has signed an agreement to do so.

Contractors or nursing facility (including ICF/MR) operators must not seek nor accept additional or supplemental payment beyond the patient-pay or MDCH ability-to-pay amount.

12.2 Pre- And Post-Payment Review/Audit

Providers are subject to pre- and post-payment review/audit or an adjustment to the reimbursement rate.

- In prepayment review, MDCH may deny reimbursement for a service until it is satisfied the service has met Medicaid guidelines.

- In post-payment review/audit, MDCH may initiate an adjustment to obtain monies paid for services that have not met Medicaid guidelines, or suspend or disenroll the provider from the Program.

12.3 Emergency Services (MHPs Only)

Emergency services to the point of stabilization, provided to a MHP enrollee inside or outside the MHP's service area, must be reimbursed by the MHP to the provider of services.

12.4 Factoring

Factoring of Medicaid accounts by any provider is prohibited. A factor is defined in federal regulations as "an organization, that is, a collection agency or service bureau which advances money to a provider for his accounts receivable which have been assigned or sold, or otherwise transferred to this organization for an added fee or a deduction of the accounts receivable." Power of attorney arrangements, under which a check is payable to the provider but can be cashed by a factor, are prohibited. However, payment may be made in accordance with an assignment from the provider to a government agency or an assignment made pursuant to a court order.

"Factor" does not include a business representative, such as a billing agent or an accounting firm, which renders statements and receives payments in the name of the individual provider as long as the business representative's compensation for this service is:

- Reasonably related to the cost of processing the claim;
- Not related, in any way, to the dollar amount to be billed or collected; and
- Not dependent upon the actual collection of payment.

This policy is not applicable to State-owned and -operated facilities.

Section 13 – Record Keeping

13.1 Record Retention

The provider must maintain, in English and in a legible manner, written records necessary to fully disclose and document the extent of services provided to beneficiaries. Necessary records would include fiscal and clinical records as discussed below. Appointment books are also considered a necessary record if the provider renders a service that is time-specific according to the procedure code billed. Examples of services that are time-specific are psychological testing (per hour), medical psychotherapy (20-30 minutes) and vision orthoptic treatment (30 minutes). The records are to be retained for a period of not less than six years from the date of service, regardless of change in ownership or termination of participation in Medicaid for any reason. This requirement is also extended to any subcontracted provider with which the provider has a business relationship.

13.2 Provider's Orders

Providers rendering or arranging services upon the written order of another provider (e.g. physician) must maintain that order for a period of six years.

13.3 Beneficiary Identification Information

Providers must retain the following beneficiary identification information in their records:

- Name;
- Medicaid ID number;
- Medical record number;
- Address, including zip code;
- Birth date;
- Telephone number, if available; and
- Any private health insurance information for the beneficiary, if available.

13.4 Availability of Records

Providers are required to permit MDCH personnel, or authorized agents, access to all information concerning any services that may be covered by Medicaid. This access does not require an authorization from the beneficiary as it is considered part of the treatment, payment and operations processes that do not require authorization under the HIPAA Privacy rule.

Providers must, upon request from authorized agents of the state or federal government, make available for examination and photocopying any record required to be maintained. (Failure to make requested copies available may result in the provider's suspension from the Medicaid Program.) In addition, records only (exclusive of billings or charges) may be released to other individuals if they have a release signed by the beneficiary authorizing access to his records.

If the beneficiary or his representative requests charges, payments, or copies of claims billed to or paid by Medicaid, the beneficiary's request (including Medicaid ID number) should be directed to the MDCH Third Party Liability (TPL) Section. (Refer to the Directory Appendix for contact information.)

13.5 Confidentiality

MDCH complies with HIPAA Privacy requirements and recognizes the concern for the confidential relationship between the provider and the beneficiary and protects this relationship using records and information only for purposes directly related to the administration of the Medicaid Program.

All records are of a confidential nature and should not be released, other than to a beneficiary or his representative, unless the provider has a signed release from the beneficiary. Providers are bound to all HIPAA privacy and security requirements as federally mandated.

If the provider receives a court order or a subpoena for medical bills, the bills should be released. At the same time, copies of the court order or subpoena, released bills, and any additional information should be sent to the MDCH TPL Section. (Refer to the Directory Appendix for contact information.)

If there is a reason to suspect a duplicate payment has been or will be made, but the payment is not assigned, the provider should contact the TPL Section. That Section will then make the necessary arrangements to collect the duplicate payment from the third-party source.

If the provider questions the appropriateness of releasing beneficiary records, he is encouraged to seek legal counsel before doing so.

13.6 Fiscal Records

The following fiscal records must be available and provided to the MDCH upon request:

- Copies of Remittance Advices (RA);
- Prior authorization requests and approvals for services and supplies (including managed care authorizations);
- Verification of medical necessity and the provider's usual and customary charge for the noncovered service;
- Record of third-party payments; and
- Copies of purchase invoices for items offered or supplied to the beneficiary.

13.7 Clinical Records

The following table contains general guidelines for clinical documentation that must be maintained by all providers except nursing facilities. Clinical records other than those listed may also be needed to clearly document all information pertinent to services that are rendered to beneficiaries. All providers must refer to their specific coverage policy for additional documentation requirements. All documentation for services provided must be signed and dated by the rendering health care professional.

For services that are time-specific according to the procedure code billed, providers must indicate in the medical record the actual begin and end time of the particular service. For example, some Physical Medicine procedure codes specify “per 15 minutes.” If the procedure started at 3:00 p.m. and ended at 3:15 p.m., the begin time and end time must be recorded in the medical record.

The medical record must indicate the specific findings or results of diagnostic or therapeutic procedures. If an abbreviation, symbol, or other "mark" is used, it must be standard, widely-accepted health care terminology. Symbols, marks, etc., unique to that provider must not be used.

Examples**:**

- When a test is performed, at a minimum, the test value for that beneficiary for that test must be noted. Additionally, the normal range of values for the testing methodology should be annotated in the record.
- When an x-ray is taken, the results or findings must be indicated. For example, a chest x-ray may indicate "no pulmonary edema present" or "no consolidation."
- When a physical examination is performed, pertinent results or readings must appear.
- If blood pressure is taken, the actual reading must appear.
- If heart, lungs, eyes, etc., are checked, the results or findings must be detailed.
- Medical/surgical procedures performed must be sufficiently documented to allow another professional to reconstruct what transpired (e.g., "I-D" is not sufficient documentation).
- When a complete physical exam is rendered, the level of service must be fully documented.
- If private duty nursing is provided, the care provided during each hour must be fully detailed.

Hospitals must retain any clinical information required to comply with 42 CFR 482.24. A nursing facility must retain any clinical information required to comply with 42 CFR 483.75(n) and the plan of care must comply with 42 CFR 483.20(d). These regulations are available from MDCH or Center for Medicare and Medicaid Services (CMS). (Hospitals and nursing facilities should refer to the “Cost Reporting” chapter of their manuals for additional record keeping requirements.)

CLINICAL RECORDS

	Date of Each Visit	Begin Time & End Time if Service is Time-Specific According to Procedure / Rev Code Billed	Presenting Symptom, Condition	Diagnosis	Patient Histories, Plans of Care, Progress Notes, Consultation Reports	Result of Exams	Records of Medications, Drugs, Assistive Devices or Appliances, Therapies, Tests, and Treatments That are Prescribed, Ordered, or Rendered	Physical Assessments and/ or Nursing activities that pertain to care provided & support the services rendered and billed	Orders for Tests & Test Results	Pictorial Records or Graphs & Written Interpretations of Tests	Identification of Specimen, Type & Source	Test Methodology	Name, Strength, Dosage, Quantity & Route of Drug, Time Administered	Ambulance Requestor's Name, Origination/ Terminating Location, Level & Type of Service	Prescribing/ Referring Physician	Transportation Information other than Ambulance
AMBULANCE	√	√	√	√	√		√	√		√			√	√		
DENTIST	√	√	√	√	√	√	√	√	√	√		√	√		√	
Family Planing	√		√	√	√	√	√	√	√	√	√	√	√		√	
MHP	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
Hearing Aid Dealer	√		√	√			√		√							
Hearing/Speech Center	√	√	√	√	√	√	√		√	√					√	
Home Health	√	√	√	√	√		√	√	√		√		√		√	
Private Duty Nursing Agency/Rn &LPN	√	√	√	√	√		√	√	√		√		√		√	
Lab	√	√		√			√		√	√	√	√			√	
Medical Supplier	√	√		√	√		√								√	
CMHSP	√	√	√	√	√	√	√	√	√	√	√	√	√		√	√
Hospice	√	√	√	√	√	√	√	√	√				√		√	
Pharmacy	√	√	√	√			√		√				√		√	
Practitioner	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	
School Based Services	√	√	√	√	√	√	√	√	√	√			√	√	√	
Vision	√	√		√								√			√	
Hospice	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√	√
MSS/ISS	√	√	√	√	√			√							√	√
MI Choice	√	√	√	√	√		√	√							√	

***** Includes M.D., D.O., D.P.M., D.C., O.D., Certified Nurse Midwife, Certified Nurse Anesthetist, Nurse Practitioner, Physical Therapist, Oral Surgeon, Medical Clinics (e.g., FQHC's, Public Health Clinics).

Section 14 - Fraud/Abuse

14.1 MDCH Program Investigation Section

The Program Investigation Section, as a federal mandate (42 CFR 455.14), is responsible for investigating all suspected Medicaid provider (fee-for-service or managed care) fraud and/or abuse. Suspected fraud and/or abuse is referred by the Program Investigation Section to the Michigan Department of the Attorney General, Medicaid Fraud Control Unit.

14.2 State Law

The Michigan Department of Attorney General uses the following State laws for investigating provider fraud and abuse:

- Medicaid False Claim Act (MCLA 400.601 et seq.) An individual, whether a provider, an employee, or an accomplice, convicted of such an activity is subject to a fine of up to $50,000 and a prison sentence of four to ten years for each count, as well as full restitution to the Medicaid Program of all funds fraudulently obtained. The provider may be suspended from participating in the Medicaid Program for a period of time and, in some instances, his license to practice his profession may be suspended or revoked.

  Examples of Medicaid fraud are:
  - Billing for Services Not Rendered: A provider bills Medicaid for a treatment or procedure that was not actually performed (e.g., laboratory tests or x-rays that were not taken, full dentures were prior authorized and billed for when a partial denture was actually supplied).
  - Billing Without Reporting Other Resources: A provider bills Medicaid the full charge for a service without reporting the amount billed and received from another source (e.g., a private insurance company) or charging the patient for the service or a co-pay for a covered benefit.
  - Billing for a Brand Name Drug Not Dispensed: A pharmacy bills Medicaid for a brand name drug when a generic substitute (at a lower cost) was actually dispensed to the beneficiary.
  - Billing for Unnecessary Services: A provider misrepresents the diagnosis and symptoms on a beneficiary's record in order to provide and bill for unnecessary tests and procedures.
  - Billing a Date of Service Other Than the Actual Date the Service was Rendered: A provider indicates a date of service other than the actual date of service that was during a time of beneficiary ineligibility or service noncoverage.
  - Receiving "Kickbacks": An ancillary provider (e.g., physical therapist, laboratory, pharmacy) may agree to pay a physician, nursing facility, or hospital administrator or owner a portion of his Medicaid reimbursement for services rendered to the physician's patient or a beneficiary residing in the facility. Payments to a physician or facility administrator or owner may be a cash payment, a vacation trip, a leased vehicle, inflated rental for space, etc. Often a "kickback" arrangement results in unnecessary tests or services being provided to the beneficiary in order to generate additional reimbursement.

- Fraudulent Cost Reports: A nursing facility or hospital including nonallowable costs or false information (e.g., understate patient census days) or including nonpatient care expenses (e.g., landscaping, interior design, or remodeling at the owner's or administrator's personal residence) in its cost report to justify a higher per diem or reimbursement rate from Medicaid.

- Social Welfare Act (MCLA 400.111d): A conviction may result in a denial, suspension, or termination of the provider's license or similar action from the Medicaid Program.

- Public Health Code (MCLA 333.16226): A conviction may result in a fine or probation from the Medicaid Program or the denial, suspension, or revocation of a provider's license.

The MDCH encourages provider assistance in reducing and reporting provider fraud and abuse in the Medicaid Program and violation of HIPAA Privacy regulations. Any provider or employee suspecting that a fraudulent activity is occurring should contact the Michigan Department of Attorney General. (Refer to the Directory Appendix for contact information.)

14.3 Federal Law

The Office of Inspector General of the United States Department of Health and Human Services (HHS) investigates provider fraud, abuse and violation of HIPAA Privacy and Security regulations under federal laws.

The following federal laws are primarily used:

- Social Security Act (Section 1909). A conviction resulting in a penalty of up to 5 years imprisonment and/or a $10,000 fine.

- Civil Monetary Penalties Law of 1981 (Section 1128A of the Social Security Act). A conviction may result in a civil monetary penalty of not more than $2,000 for each item or service, and an assessment of not more than twice the amount claimed for each such item or service in lieu of damages sustained by the federal or state agency because of the fraudulent claim.

To report fraudulent activities to the federal investigators, contact the Office of Inspector General. (Refer to the Directory Appendix for contact information.)

14.4 Patient Abuse

Under federal law, the Department of Attorney General, Health Care Fraud Division (Medicaid Fraud Control Unit) is mandated to investigate and prosecute instances of patient abuse occurring in any Michigan facility receiving Medicaid funds.

Examples of patient abuse are:

- Physical abuse, involving assaulting, striking, or sexually abusing a patient.
- Threat or perceived threat of physical or sexual abuse.
- Neglect resulting from inadequate medical or custodial care or other situations that create health risks to the patient.
- Financial abuse, including misappropriation of patient's personal funds, co-mingling of patient and facility funds.
- Use of patient funds to pay for facility operations, or theft of patient's property.

The above examples are not all inclusive.

Complaints involving suspected abuse of patients within any Michigan facility receiving Medicaid funds should be reported to the Michigan Department of Attorney General's 24-hour toll-free hotline. Complaints may also be mailed to the Attorney General's Medicaid Fraud Unit. (Refer to the Directory Appendix for contact information.)

Pursuant to section 111B of the Social Welfare Act of 1939 (PA 280, as amended, MCLA 400.11B[7]), a provider is required to make available, to authorized agents of the Department of Attorney General, any record required to be maintained as a condition of participation in the Medicaid Program.

The Michigan Department of Attorney General also is empowered to investigate and prosecute any complaint involving patient abuse by a provider that receives Medicaid funds. It does not matter whether or not the abused patient is receiving Medicaid benefits. (Patient abuse is defined as harm or threat of harm to a patient's health or welfare by a person responsible for the patient's health or welfare that occurs through non-accidental physical or mental injury, sexual abuse, or maltreatment.)

14.5 Beneficiary Fraud/Abuse

A provider can contact the local FIA in the beneficiary's county of residence to report beneficiary fraud.

The provider can also report beneficiary over-utilization of services by contacting the local FIA worker or the Beneficiary Monitoring Program. (Refer to the Directory Appendix for contact information.)

Section 15 - Provider Appeal Process

Any provider participating in, or applicant wishing to participate in, the Medicaid Program has the right to appeal any adverse action taken by MDCH unless the adverse action resulted from an action that MDCH had no control over (e.g., Medicare termination, license revocation). The method of appeal depends upon the provider type. Most providers are informed of the steps to be taken to appeal the action via the notice of adverse action. (Hospital providers may appeal at the time of adverse action, prior to the notice.) Institutional providers should refer to their respective provider manuals for the appropriate steps and time frames for appeal.

Any questions regarding this appeal process should be directed to the MDCH Administrative Tribunal & Appeals Division. (Refer to the Directory Appendix for contact information.)

Section 16 - Review of Proposed Changes

The following guidelines for the development of policies, procedures, forms, and instructions apply to the Medicaid, Children's Special Health Care Services, State Medical, and other health insurance programs administered by the MDCH.

MDCH consults with affected providers and other interested parties on those proposed changes in Medicaid Program policies, procedures, forms, and instructions which are determined significant enough to be communicated to providers by means of a provider bulletin. This consultation process involves a notification of the proposed change and the reasons for the change. MDCH includes the distribution of draft policy to those parties who have expressed interest in reviewing and commenting on the changes.

Affected provider means any enrolled provider or provider association/organization that is impacted by the proposal changes. Any affected provider or other interested party who would like an opportunity to comment on any proposed changes in his area of interest (e.g., podiatry, hospital, vision) may do so.

Visit the MDCH website to review draft policies or to request draft policies be sent to you for comment. Refer to the Directory Appendix for contact information.

You may also contact MDCH directly to request to participate in the policy promulgation process. (Refer to the Directory Appendix for contact information.)

Your request to receive draft policies must include:

- Provider's/Individual's name;
- Telephone number;
- Mailing address (and E-mail address if requesting electronic distribution);
- Involvement with the Medicaid Program (e.g., Medicaid provider, drug manufacturer, interested party);
- Association/organization represented (if applicable); and
- Specific area of interest to review and comment on (e.g., physician, ambulance, hospital, MSS/ISS, dental, long term care facilities).

Copies of all draft bulletins are sent to interested parties via e-mail, US mail and are posted on the MDCH website for 30 days. Anyone wishing to comment on proposed changes may submit comments electronically, by fax or by US mail within the comment period.

Comments received are considered and suggestions may be incorporated in the final policy if determined appropriate. Upon completion of the consultation process, a provider bulletin serves as final notice of the change. A summary of the comments made, MDCH's response, and a copy of the final bulletin are sent to those who submitted comments. Proposed changes may have to be implemented before comments are considered if specific action is ordered by governmental entities having authority over MDCH with time frames that do not allow full compliance with the consultation process. In these cases, comments are requested from affected providers and are considered for incorporation after the implementation of the change.

MDCH consults with the Health Care Advisory Council (composed of consumers, providers, and government officials) in the review of proposed policies and procedures prior to implementation. Numerous provider associations and organizations are also involved in the review process. A provider, who feels that his association or the Health Care Advisory Council adequately represents him, may not wish to be included on the provider consultation list.

Chapter X – Coordination of Benefits

Table of Contents

Section 1 - Introduction

Federal regulations require that all identifiable financial resources be utilized prior to expenditure of Medicaid funds for most health care services provided to Medicaid beneficiaries. Medicaid is considered the "payer of last resort." Coordination of Benefits (COB) is the mechanism used to designate the order in which multiple carriers are responsible for benefit payments and, thus, prevention of duplicate payments. Third party liability (TPL) refers to an insurance plan or carrier (e.g., individual, group, employer-related, self-insured or self-funded plan), commercial carrier (e.g., automobile insurance and workers' compensation), or program (e.g., Medicare) that has liability for all or part of a beneficiary's medical coverage. The terms "third-party liability" and "other insurance" are used interchangeably to mean any source, other than Medicaid, that has a financial obligation for health care coverage. Providers must investigate and report the existence of other insurance or liability to Medicaid and must utilize other payment sources to their fullest extent prior to filing a claim with the Michigan Department of Community Health (MDCH).

Billing Medicaid prior to exhausting other insurance resources may be considered fraud under the Medicaid False Claim Act if the provider is aware that the beneficiary had other insurance coverage for the services rendered.

1.1 Subrogation

When a beneficiary has a third party resource available, Medicaid has the legal right to subrogation. Federal regulations grant Medicaid the right of recovery for any amounts payable to the program. In order to recover the conditional payment, Medicaid may bring direct action in it's own right against the entity responsible for payment or against any other entity that has received payment. To be eligible for the Medicaid Program, beneficiaries must assign to MDCH the right to collect other insurance payments on their behalf.

1.2 Verification of Other Insurance

Information about a beneficiary's other insurance is available through the automated Eligibility Verification System (EVS). It is not displayed on the **mihealth card**. (Refer to the "Eligibility Chapter" of this manual for additional information, and the Directory Appendix for contact information.)

Providers must always ask the beneficiary whether or not there is other insurance coverage at the time of service. If the beneficiary identifies other insurance coverage that is not listed on the EVS, the provider must use that other insurance and report it to MDCH by contacting the Medicaid Provider Inquiry Line or Third-Party Liability Section. If the beneficiary belongs to a network, the provider must refer him to that preferred provider for services needed. (Refer to the Directory Appendix for contact information.)

If the beneficiary does not agree with the other insurance information contained in the EVS (e.g., other insurance coverage is no longer available), the provider must also contact the Medicaid Provider Inquiry Line or Third-Party Liability Section to initiate a change in the EVS. (Refer to the Directory Appendix for contact information.)

Section 2 – Categories of Other Insurance

The major categories of other insurance are:

- Commercial health insurance carriers (including managed care carriers [MCC], preferred provider organizations [PPO], point of service organizations [POS], health maintenance organizations [HMO]) and traditional indemnity policies;
- Auto Insurance (accident, no-fault);
- Workers' Disability Compensation;
- Court-Ordered Medical Support;
- General Liability Insurance; and
- Medicare.

2.1. Commercial Health Insurance

If a Medicaid beneficiary is enrolled in a commercial health insurance plan, the rules for coverage by the commercial health insurance must be followed. This includes, but is not limited to:

- Prior authorization requirements;
- Provider qualifications; and
- Obtaining services through the insurer's provider network.

Beneficiaries must use the highest level of benefits available to them under their policy. Medicaid is not liable for payment for services denied because coverage rules of the commercial health insurance were not followed. For example, Medicaid does not pay the point of service sanction amount for the beneficiary electing to go out of network. Medicaid is, however, liable for Medicaid-covered services that are not part of the commercial health insurance coverage.

Prior authorization is not necessary for situations of other insurance coverage if all of the following apply:

- The beneficiary is eligible for the other insurance and the primary insurer rules are followed, AND
- The provider is billing a standard HCPCS code that Medicaid covers and the primary insurer makes payment or applies the service to the deductible

Prior authorization is required for cases where the commercial carrier benefit has been exhausted or the service/item is not a covered benefit.

Prior authorization is necessary for all other situations, including not otherwise classified (NOC) codes.

Inappropriately recoded claims will be rejected by the MDCH even if prior authorization was issued by the Department.

The MDCH payment liability for beneficiaries with private commercial health insurance is the lesser of the beneficiary's liability (including coinsurance, copayments, or deductibles), the provider's charge, or the maximum Medicaid fee screen, minus the insurance payments and contractual adjustments. (A contractual adjustment is an amount established in an agreement with a third-party payer to accept payment for less than the amount of charges.)

Providers may enter into agreements with other insurers to accept payment that is less than their usual and customary fees. Known as "Preferred Provider" or "Participating Provider Agreements," these arrangements are considered payment-in-full for services rendered. Neither the beneficiary nor MDCH has any financial liability in these situations.

Providers must secure response(s) from other insurances (e.g., explanation of benefits, denials) prior to billing Medicaid except for the fixed co-pay amounts or payments for non-covered services. In these cases, providers must have documentation in the beneficiary's file. When billing on paper, this documentation must be submitted as an attachment to the paper claim. When billing electronically, no attachment is necessary, as all required data must be included in the electronic submission. (Refer to the Billing and Reimbursement chapter of this manual for further information.)

If payments are made by other insurance, the amount paid, whether it is paid to the provider or the beneficiary, must be reflected on the claim. It is the provider's responsibility to obtain the payment from the beneficiary if the other insurance pays the beneficiary directly. It is acceptable to bill the beneficiary in this situation. Providers may not bill a Medicaid beneficiary unless the beneficiary is the policyholder of the other insurance. Failure to repay, return, or reimburse Medicaid may be construed as fraud under the Medicaid False Claim Act if the provider has received payment from a third party resource after Medicaid has made a payment. Medicaid's payment must be repaid, returned, or reimbursed to MDCH Third Party Liability Section. (Refer to the Directory Appendix for contact information.)

2.2. Automobile Insurance (Accident, No Fault)

Under Michigan's "No-Fault" law, automobile insurance carriers are required to pay the medical expenses for injuries incurred in an automobile accident. However, in some instances, the insured's automobile policy contains a rider stating that his health insurance coverage takes priority over the automobile's insurance carrier's policy. (This also applies to Coordination of Benefits riders.) In situations where more than one individual is involved in an accident, there is a possibility that multiple automobile insurance carriers are involved. As a result, the liable insurance carrier cannot always be readily identified at the time of initial medical treatment. The "no fault" law is designed to designate an order of priority of liability. Providers must bill the automobile insurance carrier prior to billing Medicaid.

The order of responsibility to pay for medical expenses for automobile accidents is as follows:

- The insurance company of the injured party regardless of whether he was in his, or any, automobile.
- The insurance company of any resident relative of the house in which the injured party also resides.
- The insurer of the owner of the vehicle occupied. For non-occupants (pedestrians) of the vehicles, the insurer of the vehicles involved.
- The insurer of the driver of the vehicle occupied. For non-occupants (pedestrians) of the vehicles, the insurer of the drivers involved.

If a claim has been filed, providers should bill Medicaid while the other insurance claim is pending resolution. Medicaid must be billed within six months from the date of filing the "no fault" claim to keep the claim active with Medicaid. Providers must bill the appropriate procedure code, date of the accident, and any other pertinent information (e.g., the identification of the other insurance of the injured party) on the claim.

Providers may directly pursue "no fault" or other casualty cases and submit claims directly to the other insurance carriers. If liability is in question, Medicaid may be billed. Medicaid then pursues reimbursement from the other insurance through subrogation.

2.3. Workers' Disability Compensation

Workers' Disability Compensation is a system established under state law that provides payments, without regard to fault, to employees injured in the course of their employment. Workers' Disability Compensation does not cover medical care incidental to or separate from the injury. Providers must establish if the beneficiary is covered by Workers' Disability Compensation.

If a claim has been filed and is contested, providers may bill Medicaid while the claim is pending resolution by Workers' Disability Compensation. The provider must bill the appropriate procedure code, the date the claim was submitted (if known), and any other pertinent information (e.g., employer, Workers' Disability Compensation carrier, and attorney's name). Medicaid may bill the compensation carrier, or may follow up in hearings as to redemption or settlement.

2.4. Court-Ordered Medical Support

Court-ordered medical support is medical coverage for beneficiaries that the court has ordered to be paid by an individual (who is also the policyholder) other than the beneficiary. This individual could be an absent parent, a grandparent, adoptive parent, etc. The provider must pursue recovery of the other insurance payment directly from the policyholder. In instances where the policyholder does not reside with the beneficiary (e.g., an absent parent), providers are encouraged to have the custodial parent obtain a Qualifying Medical Support Order through the local Friend of the Court. This allows the provider to bill the other insurance directly (e.g., Blue Cross/Blue Shield). If there is not a Qualifying Medical Support Order on file for the beneficiary, providers must still obtain the other insurance payment from the policyholder. Refer to the Directory Appendix for contact information.

2.5. General Liability

General liability insurance is coverage that generally pertains to claims arising out of the insured's liability for injuries or damage caused by the ownership of property, manufacturing operation, contracting operations, sale or distribution of products, or the operation of machinery, as well as professional services. If the beneficiary's injury is not work- or automobile-related, the beneficiary's medical services may be covered by another insurance carrier (e.g., homeowner's insurance policy). This insurance carrier is considered primary and must be billed according to the rules of the insurance carrier.

2.6. Medicare

2.6.A. Medicare Eligibility

Many beneficiaries are eligible for both Medicare and Medicaid benefits. If a provider accepts the individual as a Medicare beneficiary, they must also accept the individual as a Medicaid beneficiary.

Medicaid identifies Medicare-eligible beneficiaries in several ways, including, but not limited to,:

- Beneficiary Data Exchange (Bendex), which is a listing of Medicare-eligible beneficiaries that may be compared to the Medicaid eligibility file.

- Rejects claims submitted for beneficiaries age 65 or older who have not aplied for Medicare coverage. Providers are instructed to have the beneficiary contact the Social Security Administration to apply.

Medicaid beneficiaries may apply for Medicare at any time and are not limited to open enrollment periods. Beneficiaries may be eligible for Medicare if they are:

- 65 years of age or older;
- A disabled adult (entitled to SSI or RSDI due to a disability); or
- A disabled minor child.

2.6.B. Medicare Part A

Since Medicare Part A pays for care in an inpatient hospital, nursing facility, services provided by a home health agency or in other institutional settings, Medicaid's reimbursement for services under Medicare Part A may vary.

> *If MDCH is paying a beneficiary's Medicare Part B premium and the beneficiary does not have free Medicare Part A, MDCH also pays the beneficiary's Medicare Part A premium.*

MDCH monitors beneficiary files to identify all beneficiaries who currently have Medicare Part B coverage only, and have Part B buy-in. Once these beneficiaries are identified, MDCH automatically processes Part A buy-in.

When a beneficiary has incurred Medicare Part A charges and is eligible for, but does not have, Medicare Part A buy-in, the claim is rejected. Providers must wait for the beneficiary to obtain Medicare coverage, then bill Medicare for services rendered. After Medicare's payment is received, Medicaid should be billed for any co-insurance and/or deductible amounts. For Medicare Part A and Part B/Medicaid claims, Medicaid's liability never exceeds that of the beneficiary.

To expedite the buy-in process, providers may notify MDCH, in writing, when a beneficiary age 65 or older, covered by Medicare Part B only, is admitted to an inpatient hospital. (Refer to the Directory Appendix for Medicare Buy-In Unit contact information.) The following information is required:

- Beneficiary's name, date of birth, and Medicaid ID number;
- Health insurance claim number (HICN);
- Inpatient hospital admission date; and
- Hospital name, address, and Medicaid provider ID number.

Special points to remember:

- Medicaid does not pay for any portion of the services Medicare would have otherwise covered if a provider's error prevents Medicaid from buying-in Medicare Part A.

- To bill a claim when Medicare Part A coverage for Medicare/Medicaid beneficiaries is exhausted prior to an admission or during an inpatient hospital stay, refer to the "Billing and Reimbursement" chapter of this manual.

- To bill a claim when no Medicare payment has been made because the amount of Medicare co-insurance, plus the amount for lifetime reserve days, is greater than the Medicare diagnosis-related group (DRG) amount, refer to the "Billing and Reimbursement for Institutional Providers" chapter of this manual.

2.6.C. Medicare Part B

Medicare Part B covers practitioner's services, outpatient hospital services, medical equipment and supplies, and other health care services. When a beneficiary is eligible for and enrolled in Medicare Part B, Medicare usually pays for a percentage of the approved Medicare Part B allowable charges and Medicaid pays the applicable deductible and/or co-insurance up to Medicaid's maximum allowable amount. Coverage for outpatient therapeutic psychiatric coverage varies.

Beneficiaries are encouraged to enroll in Medicare Part B as soon as they are eligible to do so. A beneficiary's representative can apply for Medicare Part B benefits on behalf of the beneficiary. After the beneficiary's death, Family Independence Agency (FIA) is responsible for making the application to the Social Security Administration to cover medical services provided prior to the death.

2.6.D. Medicare Buy-in

If a beneficiary is eligible for Medicare but has not enrolled, he can do so at any time throughout the year through buy-in. If the beneficiary is unable to pay the Medicare premiums, Medicaid may pay the premiums through a contractual agreement (called the "Medicare Buy-In Agreement") with the Social Security Administration. However, Medicaid cannot "buy-in" for the beneficiary until they apply for Medicare and the Social Security Administration is aware that they are Medicaid-eligible.

Some dual-eligible beneficiaries are classified as:

Qualified Medicare Beneficiaries (QMB)	Medicaid pays Medicare Parts A and B premiums for these individuals, and reimburses providers for Medicare co-insurance and/or deductible amounts only to the extent that the total payment does not exceed the Medicaid maximum allowable amount. **NOTE:** These beneficiaries are identified by scope/coverage code 2B. Physicians and suppliers should be aware that services provided to QMBs are reimbursed on a Medicare assignment basis only. If a provider knowingly bills for Medicare services on other than an assignment basis, the Federal Department of Health and Human Services can seek sanctions.
Specified Low Income Medicare Beneficiaries (SLM/SLMB)	Medicaid pays **only** the Medicare Part B premiums for these individuals. Medicaid will not reimburse providers for any services rendered to the beneficiary. No **mihealth card** is issued to these individuals.
Additional Low Income Medicare Beneficiaries (ALMB)	Medicaid pays only the Medicare Part B premiums for these individuals. Medicaid will not reimburse the provider for any services rendered to the beneficiary. No **mihealth card** is issued to these individuals.

2.6.E. Medicaid Liability

If Medicare has paid 100 percent of the allowable charges and there is no co-insurance involved, then Medicaid has no payment liability.

Neither the beneficiary nor Medicaid is liable for any difference in the amount billed by the provider and Medicare's allowable fee.

For Medicare-covered services, Medicaid reimburses up to the Medicare-enrolled beneficiary's obligation to pay (i.e., co-insurance and deductibles) or the Medicaid allowable amount, whichever is less.

If the Medicare portion of a Medicare-covered service has not been paid by Medicare for a beneficiary enrolled in Medicare Part B, MDCH rejects the claim.

When a Medicaid beneficiary is eligible for, but not enrolled in, Medicare Part B, MDCH rejects any claim for Medicare Part B services. This is done in order to notify providers that beneficiaries must pursue Medicare through the Social Security Administration.

Medicare coverage is not available for a Medicaid beneficiary who is 65 years or older and is an alien who has been in the country less than five consecutive years.

If Medicare reimburses for the service, Medicaid does not require prior authorization for the service.

Approximately twice per year, MDCH issues an MW-861 Report which identifies beneficiaries who are retroactively eligible for Medicare. Medicaid payment for services provided to these beneficiaries is adjusted to recoup all monies except the Medicaid liability, and recovered via an automated claim adjustment. Providers are notified when these adjustments occur. Providers should refer to the MW-861 Report for beneficiary details. If a discrepancy in payment exists, the provider should contact the Provider Inquiry or Third Party Liability staff. (Refer to the Directory Appendix for contact information.)

Beneficiaries cannot be charged for Medicaid-covered services, except for approved co-pays or deductibles, whether they are enrolled as a fee-for-service beneficiary, or MDCH is paying the HMO premiums to a contracted health plan, or services are provided under CMHSP or Coordinating Agency (CA) capitation.

2.6.F. Exceptions to the Billing Limitation

When a delay in payment from Medicare causes a delay in billing Medicaid, an exception may be made if the provider can document that Medicare was billed within 120 days of the date of service and Medicaid was billed within 120 days of the date of payment or rejection by Medicare. Medicaid payment will be made provided all other requirements (e.g., beneficiary eligibility,

medical necessity) are met. A copy of the Medicare claim submitted and Medicare's response must be attached to the Medicaid paper claim to document Medicare's delay. If billing electronically, a note should be added in the "Remarks" segment that the late billing is due to Medicare's delay in processing the claim. (Refer to the "Billing and Reimbursement" chapter of this manual for additional information.)

2.6.G. Special Considerations for Inpatient Hospital Claims

Due to the nature of DRG calculations, the following instructions must be used when completing an inpatient hospital claim:

- All Medicare and other insurance payment information should be indicated on the claim that contains the Discharge Status Code that indicates the beneficiary has been discharged from the facility. If the inpatient service requires two claims, payment information (e.g., total other insurance payment, Medicare co-insurance and deductible) must be included on the claim for the last date of service for the inpatient stay. Interim claims should not reflect a payment.

- Medicare Part A and Part B charges must be combined on one claim.

- The actual total Medicare Part A and Part B payment must be indicated on the inpatient hospital claim/adjustment. This amount is not the "contract" charge. The amount billed may equal both the sum of the co-insurance and deductible amounts; however, in order to provide proper reimbursement, the actual total Medicare Part A and Part B payment must be indicated.

- When a beneficiary has Medicare Part B only, this must be reflected in the "Remarks" Section of the claim. Additionally, the claim must reflect the 20 percent amount due from Medicaid. The Medicare Part A and Part B payment is the 80 percent of the allowable charges covered by Medicare for Part B services.

For Medicare reimbursement, the "amount billed" services does not equal the sum of the co-insurance and deductible items. It must be calculated as the gross hospital charges **minus** all Medicare payments, **minus** other insurance payments, and **minus** any patient-pay and/or co-payment amount. If a claim is submitted with the "amount billed" equal to zero, other payment greater than or equal to Medicaid's payment, or a negative amount, Medicaid does not make a payment. If there is a balance to be billed to Medicaid, the hospital may bill Medicaid for covered services only.

2.6.H. Lifetime Reserves Days (LRD)

Medicare allows a one-time additional 60 days of coverage known as Lifetime Reserve Days (LRD). A Medicaid beneficiary who has Medicare Part A must use these 60 days before Medicaid makes a payment, except for deductibles and co-insurance.

2.6.I. Outpatient Hospital Laboratory Services

Medicare pays most diagnostic and clinical laboratory tests at 100 percent. Therefore, Medicaid has no payment liability.

2.6.J. Psychiatric Services

Diagnostic outpatient hospital psychiatric physicians services, including the initial psychiatric diagnostic and evaluation interview, family counseling and psychological testing, are reimbursed as a Medicare Part B service.

Medicare Part B reimbursement for therapeutic outpatient hospital services is different than reimbursement for other Part B services.
Medicare applies a special 37.5 percent fee reduction to the amount approved by Medicare. (The 37.5 percent fee reduction does not appear on the Medicare EOB.) Medicaid is liable for the 37.5 percent fee reduction, the annual Part B deductible, and the 20 percent co-insurance amount, up to the Medicaid maximum allowable amount.

2.6.K. Other Insurance Carrier ID List

The Other Insurance Carrier ID List on the MDCH website provides a listing of codes assigned by MDCH for each insurance carrier. The list is available by carrier code and by carrier name and is updated quarterly. All third-party carriers must be used to the fullest extent possible, prior to billing Medicaid and Children's Special Health Care Services (CSHCS) Programs.

Major carriers (e.g., Blue Cross/Blue Shield, AETNA) are listed by the Other Insurance Code with the home offices first, usually followed by the district offices. Providers should submit the other insurance claims to the nearest office. If the provider is in doubt, claims should be sent to the home office of the carrier.

Section 3 – Special Considerations

3.1 Contractual Care Arrangements for Long Term Care

A **"life care contract"** is created when an individual enters into an agreement with a continuing care retirement community to provide for all the individual's needs, including health care, for the rest of his life. The individual pays a one-time entrance fee and monthly payments thereafter. The continuing care retirement community assumes full financial responsibility if the individual is unable to make his monthly payments at a later date. An individual with a life care contract is not eligible for Medicaid.

A **"continuing care contract"** is created when an individual enters into an agreement with a continuing care retirement community to provide or pay for all, or some of, the individual's medical care for the rest of his life. The individual pays a one-time entrance fee and monthly payments thereafter. There are three types of continuing care contracts:

3.2 Master Medical

All insurance coverage, including Master Medical policy riders, must be used before filing a claim with Medicaid. If the beneficiary has a Master Medical policy rider (e.g. Blue Cross/Blue Shield), providers must identify whether the provider or policyholder must bill. If the policyholder must bill, the provider must provide a statement of charges to the beneficiary or policyholder to use when billing Master Medical. If there is a court order for medical support that includes Master Medical, the custodial parent may obtain a qualified medical support order for providers to be paid directly from the insurance carrier. Whether the payment is made to the policyholder or the provider, the provider must report it as other insurance payment on the bill submitted to Medicaid. Providers must pursue recovery of the insurance payment if it is made directly to the policyholder. The beneficiary, or his representative, must not be billed for this payment unless the beneficiary is the policyholder.

3.3 Co-insurance/Deductible and/or Co-payment

Medicaid responsibility for payment of co-insurance/deductible and co-payment amounts is:

Co-pay	Medicaid pays fixed co-pay amounts up to the Medicaid-allowable amounts as long as the rules of the other insurance are followed. The provider must bill the fixed co-pay amount as the charge.
Co-pay and deductible	Medicaid pays the appropriate co-pay amounts and deductibles up to the beneficiary's financial obligation to pay or the Medicaid allowable amount, whichever is less. If the other insurance has negotiated a rate for a service that is lower than the Medicaid allowable amount, that amount must be accepted as payment in full and Medicaid cannot be billed.
Medicaid services not covered by an other insurance	If the other insurance does not cover a service that is a Medicaid-covered service, Medicaid will reimburse the provider up to the Medicaid allowable amount if all the Medicaid coverage rules are followed.

The MDCH cannot be billed for co-pays, deductibles, or any fees for services provided to beneficiaries enrolled in a Medicaid Health Plan (MHP), CSHCS Special Health Plan (SHP), or who are receiving services under Community Mental Health Services Program (CMHSP) or Substance Abuse Coordinating Agencies (CA) capitation. Beneficiaries are responsible for payment of all co-pays and deductibles allowed under the MHP/SHP/CMHSP/CA contract with MDCH. If the beneficiary with other insurance coverage is enrolled in a MHP, SHP or receiving services under a CMHSP or CA capitation, the MHP/CMHSP/CA assumes the Medicaid payment liabilities.

Beneficiaries cannot be charged for Medicaid-covered services, except for approved co-pays or deductibles, whether they are enrolled as a fee-for-service beneficiary, or MDCH is paying the HMO premiums to a contracted health plan, or services are provided under CMHSP or CA capitation.

(Refer to Section 2.6.E for additional information on Medicare claims.)

3.4 Claim Replacement

A claim replacement should be submitted if another insurance makes a payment subsequent to Medicaid's payment. (For specific claim replacement instructions, refer to the "Billing and Reimbursement" chapter of this manual.)

DIRECTORY APPENDIX

MDCH Website Address: www.michigan.gov/mdch

CONTACT	PHONE # / FAX #	MAILING/E-MAIL/WEB ADDRESS	INFORMATION AVAILABLE
PROVIDER ASSISTANCE			
Provider Support/Inquiry 8 am to 5 pm M-F EST	800-292-2550	MDCH Provider Support PO Box 30731 Lansing, MI 48909-8231 providersupport@michigan.gov	Provider resource for policy clarification, billing assistance
Provider Enrollment	517-335-5492 fax 517-241-8233	MDCH/Medicaid Payments Division Provider Enrollment Unit PO Box 30238 Lansing, MI 48909	Provider enrollment information and forms, update provider information, billing agent authorizations
BENEFICIARY ASSISTANCE			
Beneficiary Helpline	800-642-3195		Beneficiary resource for eligibility, enrollment and coverage assistance, **mihealth card** replacements
Pharmacy Beneficiary Helpline	877-681-7540 fax 800-250-6950		
CSHCS Parent Participation Program Family Phone Line	800-359-3722		
MIEnrolls (Michigan Enrolls) M-W 8am to 8pm Th-F 8am to 6pm Sat 9am to 1pm	888-367-6557 TTY: 888-263-5897	Michigan Enrolls PO Box 30412 Lansing, MI 48909	Application and enrollment information
MIChild/Healthy Kids	888-988-6300 or 888-858-5929	FIA Office Services Division Grand Tower, Ste. 203 PO Box 30037 Lansing, MI 48909 On-line application https://eform.state.mi.us/michild/intro1.htm	Applications and eligibility information
ELIGIBILITY VERIFICATION			
Eligibility Verification (routine)	800-444-4336	MediFAX	Eligibility information within the last 12 months
Eligibility Verification (dates of service >1 yr)	800-444-4336 ext. 2850	MediFAX	Eligibility information for date over 12 months
Eligibility Verification (newborns)	Fax 517-373-1437	msaess@michigan.gov	Eligibility information for newborns IF unavailable through routine process.
Eligibility Verfication (out-of-state)	517-335-5477		
CSHCS Eligibility	517-335-8983		Eligibility information related to Children's Special Health Care Services beneficiaries
MediFAX EDI Sales Representative	800-819-5003		Information regarding swipe card and other available services
MediFAX Customer Service	615-565-2010		
AUTHORIZATION OF SERVICES (Prior Authorization)			
Prior Authorization (Medicaid & CSHCS)	800-622-0276 fax 517-335-0075	MDCH Services Review & Evaluation PO Box 30170 Lansing, MI 48909	Prior authorization for all services except dental, hospital, & pharmacy

Prior Authorization - Dental	800-622-0276 or 517-335-5090 fax 517-335-0075	MDCH Dental Prior Authorization PO Box 30170 Lansing, MI 48909	Prior authorization of dental services for Medicaid and CSHCS
Prior Authorization – Non-Psychiatric Inpatient Admissions	800-727-7223	Michigan Peer Review Organization 40600 Ann Arbor Rd., Ste. 100 Plymouth, MI 48170	
Prior Authorization – Psychiatric Inpatient Admissions	Refer to local Community Mental Health Services Program		
Prior Authorization – Pharmacy	877-864-9014 fax 888-603-7696	First Health Services Corp.	
Pharmacy Clinical Call Center	877-624-5204 fax 877-888-6370		
POLICY, BILLING RESOURCES, & FORMS			
Medicaid Policy Manuals/Bulletins	517-241-7903 fax 517-335-5136	www.michigan.gov/mdch click on Provider, Information for Medicaid Providers, Medicaid Policy	Copies of proposed policy drafts and final policy bulletins available on-line. Policy manuals can be ordered.
Draft Medicaid Policy	517-241-7903	msadraftpolicy@michigan.gov	To receive copies of draft policies
MDCH Procedure Code Databases/Fee Screens	517-241-7903 fax 517-335-5136	www.michigan.gov/mdch click on Provider, Information for Medicaid Providers, Medicaid Fee Screens	MDCH-covered procedure codes, parameters, and fee screens available on-line.
Washington Publishing Co.		PMB 161 5284 Randolph Rd Rockville, MD 20852-2116 www.wpc-edi.com	Information regarding claim adjustment reason/remark codes reported on remittance advice.
Electronic Billing Resources		www.michigan.gov/mdch click on Providers, HIPAA	835 & 837 Companion Guides Testing Instructions MDCH Electronic Submission Manual
Miscellaneous Transactions Unit (MTU)	517-335-5477	MDCH/Miscellaneous Transactions Unit PO Box 30239 Lansing, MI 48909	Out-of-state and non-enrolled provider claims
Delta Dental Customer & Claims Services Department	800-482-8915		Information related to Health Kids Dental enrollees, services, and claims
OCR Coordinator	517-335-5558	MDCH Attn: OCR Coordinator 3423 N. MLK Jr. Blvd. Lansing, MI 48909 OCRCoordinator@michigan.gov	Information related to paper claim readability
Paper Claim Submission Address		MDCH PO Box 30043 Lansing, MI 48909	HCFA 1500, UB-92, and ADA 2000 claims are to be mailed to the address indicated. No other paper claim formats are accepted.
Claim Attachment Submission (Hospitals only)		MDCH/Medicaid Payments Division PO Box 30732 Lansing, MI 48909-8232	Hospitals may send attachments for claims submitted electronically.
Sterilization & Hysterectomy Form Submission	Fax 517-241-7856		Form may be downloaded from the MDCH website at: www.michigan.gov/mdch Click on Providers, Information for Medicaid Providers, Medicaid Provider Forms & Other Resources
Refund of Payment		MDCH Cashier's Unit PO Box 30437 Lansing, MI 48909	
Medicare Buy-In Unit	517-335-5488 fax 517-335-0478	MDCH/Buy-In Unit Lewis Cass Bldg 320 S. Walnut Lansing, MI 48913	

Third Party Liability Section	800-292-2550 fax 517-335-8868	MDCH/TPL 3423 N. MLK Jr. Blvd., Ste. 317 Lansing, MI 48909 TPL@michigan.gov	
Forms Distribution	517-373-6401 Fax 517-241-1164	MDCH/Forms Distribution Lewis Cass Bldg. 320 S. Walnut Lansing, MI 48933	Many required forms are now available on-line at www.michigan.gov/mdch Click on Providers, Information for Medicaid Providers, Medicaid Provider Forms & Other Resources
HEALTH PLAN INFORMATION			
CSHCS Contract Managers	517-241-7186	www.michigan.gov/mdch	Information regarding CSHCS Special Health Plans
Medicaid HP Contract Managers	517-335-5500	www.michigan.gov/mdch	Information regarding Medicaid Health Plans
APPEALS, FRAUD, AND OTHER MISCELLANEOUS CONTACTS			
Appeals (Provider)	517-335-5231	MDCH Administrative Appeals Division PO Box 30195 Lansing, MI 48909	Ambulatory, hospital, and nursing facility appeals
Appeals (Beneficiary)	877-833-0870 or 517-335-8911 fax 517-335-9180	Administrative Tribunal & Appeals Division PO Box 30195 Lansing, MI 48909	Beneficiaries may request hearing on benefit denial.
Appeals (Beneficiary Monitoring Program)	517-335-5060	MDCH Beneficiary Monitoring Program PO Box 30479 Lansing, MI 48909-7979	
Beneficiary Monitoring Program	517-335-5060	MDCH Beneficiary Monitoring Program PO Box 30479 Lansing, MI 48909-7979	Report beneficiary fraudulent, overuse, or misuse of Medicaid services
Friend of the Court	517-373-5975 fax 517-373-8740	Friend of the Court Bureau State Court Administrative Office Michigan Hall of Justice PO Box 30048 Lansing, MI 48909 focb@courts.michigan.gov	
MDCH Program Investigation Section	866-428-0005	PO Box 30479 Lansing, MI 48909-7979	Report suspected Medicaid provider fraud and/or abuse www.michigan.gov/mdch (click on Inside Community Health, Fraud & Abuse)
Office of the Inspector General	313-226-4258	Room 512 – Federal Courthouse Detroit, MI 48226	Report violations of federal law
Office of the Inspector General, Office of Investigation	517-335-3900	235 S. Grand, Ste. 1115 Lansing, MI 48933	
Department of Attorney General	800-242-2873 fax 517-241-6515	Health Care Fraud Division Department of the Attorney General PO Box 30218 Lansing, MI 48909 HCF@AG.michigan.gov	Report Medicaid provider fraud
Michigan Department of Civil Rights	800-482-3604		Report violations of handicapper rights.
U.S. Department of Justice Office of Civil Rights	800-552-6843		Report violations of handicapper rights.
LTC Ombudsman	800-292-7852		
MDCH OBRA Office		Baker-Olin West, Ste 303 3423 N. Martin Luther King Blvd. Lansing, MI 48909	